OPTIMAS by INMODE

Elite Aesthetics

Informed Consent for Lumecca

Patient Name: _____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your healthcare professional prior to signing the consent form.

THE TREATMENT

Lumecca is a non-invasive intense pulse light (IPL) technology that utilizes the technology for skin rejuvenation and pigmented and vascular lesion improvement. Pigmented lesions will become darker for a period of 1-2 weeks before starting to lighten. Blood capillaries will clot and appear darker for 1-2 weeks before disintegration. Local inflammation around the lesions, manifested as some redness and swelling may accompany the response as part of the healing process. Some skin tightening may occur immediately which may decline for 1-2 months but will improve again as new collagen fibers are produced. All 3 conditions (brown discoloration, red discoloration, and loose skin) may improve simultaneously. The treatment requires anesthesia that involves topical cream. The treatment involves 1-3 sessions approximately 3-6 weeks apart according to treatment parameters and individual response. **Initial** ____

UNSUITABLE CONDITIONS TO RECEIVING TREATMENT

The following conditions APPLY to me:

- ☐ Pregnancy or nursing
- ☐ Under 18 years of age
- ☐ Permanent implant in the treated area such as metal plates and screws, silicone implants, or an injected chemical substance
- ☐ Current or history of cancer, especially skin cancer, or pre-malignant moles
- ☐ Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or the use of immunosuppressive medication(s)
- ☐ Severe concurrent conditions such as cardiac disorders, epilepsy, uncontrolled high blood pressure, and liver or kidney disease
- ☐ A history of diseases stimulated by heat such as herpes simplex in the treatment area(s)
- ☐ Any active condition in the treatment area(s) such as sores, psoriasis, eczema, and rash, as well as excessively/freshly tanned skin
- ☐ History of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry and fragile skin
- ☐ Any medical condition that might impair skin healing
- ☐ Poorly controlled endocrine disorders such as diabetes or thyroid dysfunction
- ☐ Any surgical, invasive, ablative procedure in the treatment area(s) in the last 3 months or before complete healing
- ☐ Tattoos, permanent makeup, pigmented lesions (to be kept)
- ☐ Use of isotretinoin (Accutane) in the last 6 months

Initial ____

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1.) local pain; 2.) skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of skin pigmentation (hyper- or hypo-pigmentation); and 3.) scarring. Although these effects are rare and expected to be temporary, redness and swelling may last up to 3 weeks and are part of a normal reaction to the treatment. Burns and resulting pigmentation change and scarring are rare and may happen in dark skin that is not taken care of according to instructions. Tiny scabs appear on the face for a few days as part of a normal healing process; however, makeup may be applied as soon as 1-3 days after the session to mask them and any residual redness. Any adverse reaction should be reported immediately.
Initial ____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me. **Initial** ____

PAYMENT

I understand that this is an "elective" procedure used for cosmetic purposes and that payment is my responsibility and is expected at the time of treatment. It is not covered by insurance and no refunds will be given for treatments received. **Initial** ____

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time. **Initial** ____

PUBLICITY MATERIALS

I authorize before, during, and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for educational and marketing purposes without disclosing my identity (eyes will be masked in the photographs). I understand that video may be taken of my procedure for educational and marketing purposes. I hold Elite Aesthetics harmless for any liability resulting from these productions. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs and/or videos.
Initial ____

RESULTS

I understand that I have to comply with the treatment schedule, otherwise results may be compromised. I understand that not everyone is a candidate for this treatment and results may vary; therefore, there is no guarantee as to the results that may be obtained. **Initial** ____

I understand this is an elective procedure and I hereby voluntarily consent to treatment with Lumecca. The procedure has been fully explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history, I will notify the healthcare professional who treated me immediately. I also state that I read and write in English.

Patient name (printed)	*Patient signature*	*Date*

Health History Completed? □ Yes □ No

Head/Neck Examination Completed? □ Yes □ No

I am the treating healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Practitioner name (printed)	*Practitioner signature*	*Date*

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